

# CITY OF SCOTTSDALE 2008/2009 BENEFITS ENROLLMENT/CHANGE FORM

<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change in Enrollment <input type="checkbox"/> Dependent change <input type="checkbox"/> Termination of Coverage		Qualifying Event: _____ Qualifying Event Date & Effective Date: _____	
FOR HUMAN RESOURCES USE ONLY _____ Original to Medical File _____ Copy to Payroll on: _____ COBRA Notice Sent _____			Received on: _____
Employee Last Name		First Name, MI	
Employee ID Number			
Date of Birth		Home Phone	
Work Phone			
<b>MEDICAL</b> <input type="checkbox"/> CITY OF SCOTTSDALE EPO MEDICAL Aetna Open Access Elect Choice (408) <input type="checkbox"/> CITY OF SCOTTSDALE PPO MEDICAL MMSI Health Tradition (410) <input type="checkbox"/> CITY OF SCOTTSDALE PPO MEDICAL Aetna Open Choice (418) <input type="checkbox"/> WAIVE MEDICAL If you are a full time employee, you must provide proof of other coverage <b>LEVEL OF COVERAGE</b> Is this a level of coverage change <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Employee AND <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner * <input type="checkbox"/> Child(ren) <input type="checkbox"/> Domestic Partner's Child(ren)*		<b>DENTAL</b> <input type="checkbox"/> ASSURANT DENTAL *HMO (425) Dental Office ID# _____ * <input type="checkbox"/> CITY OF SCOTTSDALE PPO DENTAL (420) Delta Dental of Arizona <input type="checkbox"/> NO DENTAL <b>LEVEL OF COVERAGE</b> <input type="checkbox"/> Employee AND <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner * <input type="checkbox"/> Child(ren) <input type="checkbox"/> Domestic Partner's Child(ren) *  * Dental Office ID# - The dental office you choose will be applicable for you and your dependents unless you specify a different dental office for your dependents in the dependent section of the back of this form.	
<b>SHORT TERM DISABILITY</b> <b>WEEKLY BENEFIT (430)</b> <input type="checkbox"/> No Short Term Disability <input type="checkbox"/> \$100/week (01) <input type="checkbox"/> \$200/week (02) <input type="checkbox"/> \$250/week (03) <input type="checkbox"/> \$300/week (04) <input type="checkbox"/> \$350/week (05) <input type="checkbox"/> \$400/week (06) <input type="checkbox"/> \$500/week (07) (Short Term Disability Coverage cannot exceed 70% of your weekly salary.)			
<b>HEALTH CARE SPENDING ACCOUNT</b> (455)			
<input type="checkbox"/> NO			
<input type="checkbox"/> YES Designate Annual Amount: \$ _____ (Maximum \$4,000 per calendar year, deduction is taken 24 pay periods per year.)			
<b>DEPENDENT CARE ASSISTANCE PLAN</b> (460)			
<input type="checkbox"/> NO			
<input type="checkbox"/> YES Designate Annual Amount: \$ _____ (Maximum \$5,000 per calendar year, deduction is taken 26 pay periods per year.)			

**TWO SIDED FORM – BE SURE TO COMPLETE REVERSE SIDE**

**DEPENDENTS (LIST ALL DEPENDENTS TO BE ENROLLED)**

Spouse Name (Last, First MI)		Date of Birth	Gender
Spouse is covered on the following plan(s): <input type="checkbox"/> Medical <input type="checkbox"/> Dental, if Assurant give dependent's dental office #:			
Domestic Partner's Name* (Last, First MI)		Date of Birth	Gender
Domestic Partner is covered on the following plan(s): <input type="checkbox"/> Medical <input type="checkbox"/> Dental, if Assurant give dependent's dental office #:			
Dependent 1 Name (Last, First MI)		Date of Birth	Relationship <input type="checkbox"/> Child <input type="checkbox"/> Legal Dependent <input type="checkbox"/> Dom Partner Child
Dependent 1 is covered on the following plan(s): <input type="checkbox"/> Medical <input type="checkbox"/> Dental, if Assurant give dependent's dental office #:			
Dependent 2 Name (Last, First MI)		Date of Birth	Relationship <input type="checkbox"/> Child <input type="checkbox"/> Legal Dependent <input type="checkbox"/> Dom Partner Child
Dependent 2 is covered on the following plan(s): <input type="checkbox"/> Medical <input type="checkbox"/> Dental, if Assurant give dependent's dental office #:			
Dependent 3 Name (Last, First MI)		Date of Birth	Relationship <input type="checkbox"/> Child <input type="checkbox"/> Legal Dependent <input type="checkbox"/> Dom Partner Child
Dependent 3 is covered on the following plan(s): <input type="checkbox"/> Medical <input type="checkbox"/> Dental, if Assurant give dependent's dental office #::			
Dependent 4 Name (Last, First MI)		Date of Birth	Relationship <input type="checkbox"/> Child <input type="checkbox"/> Legal Dependent <input type="checkbox"/> Dom Partner Child
Dependent 4 is covered on the following plan(s): <input type="checkbox"/> Medical <input type="checkbox"/> Dental, if Assurant give dependent's dental office #:			

Additional dependents may be listed on a separate page.

**AUTHORIZATION:** By execution of this enrollment form, I understand that I may not change the election during the year except in the event of a life change. I authorize the City of Scottsdale to make the necessary before-tax and after-tax payroll deduction(s). I also understand that I am responsible for reimbursement to the City for any benefit amount paid to me/for me in advance of my payroll deduction. I authorize the City of Scottsdale to obtain any medical records regarding claims for benefits by my covered dependent(s) or me under an insurance or health plan sponsored by the City. I further authorize my health care provider to furnish the City (or its representative) any medical information concerning any claim made by my covered dependent(s) or me. By my signature, I certify that the information on this form is true and correct, and that the listed dependents are my legal dependents.

✕ Signature \_\_\_\_\_ Date \_\_\_\_\_

HR Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*DOMESTIC PARTNERSHIP COVERAGE**

In addition to all other rules and conditions of city insurance coverage, the following apply to domestic partners coverage: In order for an employee to enroll a domestic partner for insurance coverage, both the employee and the domestic partner must complete the Domestic Partnership Affidavit. The affidavit must be approved by City of Scottsdale Human Resources prior to the commencement of coverage. Those with affidavits already on file do not have to resubmit. The portion of the insurance premium paid by the employee for domestic partner and children of the domestic partner is paid on an after-tax basis. The portion of the premium paid by the City for domestic partner and children of the domestic partner is reported to the Internal Revenue Service as taxable income to the employee. City employees who have domestic partnership insurance coverage are required to complete a Termination of Domestic Partnership form within 30 days of the termination of the domestic partnership. Children of a domestic partner may enroll for coverage only if the domestic partner is enrolled for coverage

**QUALIFIED LIFE STATUS CHANGES**

You may not make changes to your benefit plans until the next open enrollment unless you experience a qualified life status change such as the birth of a child, marriage or divorce. If you experience a qualified life status change, you may add or cancel dependents but you may not change plans. You must notify HR within 30 days of a qualifying life status change. It is your responsibility to notify HR when a dependent (spouse/domestic partner or child) is no longer eligible for coverage. Failure to cancel an ineligible dependent from your coverage within 30 days will make you responsible for any claims incurred by an ineligible dependent and may result in disciplinary action up to and including termination.